# PART 2
# BASIC ELIGIBILITY CRITERIA

## SECTION 1 SCOPE OF THE PROGRAM

The purpose of MaineCare is to provide Maine residents with access to health care. It is the goal of the Department to assist Maine residents in obtaining all of the benefits to which they are entitled under MaineCare.

MaineCare is the name used by the State of Maine to encompass a number of programs that help individuals pay for health care costs. The programs are:

**Medicaid** (Title XIX of the Social Security Act). To be enrolled in Medicaid an individual must be eligible under one of the Medicaid categories listed below. Each category has its own eligibility rules.

Categorically Needy – This Medicaid category is made up of different coverage groups. An individual qualifies for Medicaid in this category if they meet the requirements of one of the Categorically Needy coverage groups. There are a number of Family - Related and SSI - Related Categorically Needy coverage groups.

Medically Needy – This Medicaid category provides coverage for individuals whose income or assets are too high to qualify for any of the coverage groups in Categorically Needy. Usually coverage is gained by meeting a deductible or “spend-down”.

Medicare Buy-In (Medicare Savings Program (MSP)) – This Medicaid category is a benefit for those who are entitled to Medicare Part A and who meet certain income criteria. Depending on income, the benefit is payment of Medicare Part B premium or payment of Medicare Part A and B premiums as well as coinsurance and deductibles.

Medicaid Waiver Groups – These are special categories approved by the Center for Medicare and Medicaid Services (CMS) under which an individual can become enrolled in Medicaid who might not otherwise be eligible. Examples are the Home and Community Based Waivers, the HIV Waiver and the Non-Categorical Waiver.

**Cub Care** (Children’s Health Insurance Program [CHIP], Title XXI of the Social Security Act) – This program provides coverage for children under the age of 19 with higher income guidelines and different eligibility rules than Medicaid.

In addition to MaineCare, OIAS administers five State funded benefits found in this manual:

**Health Insurance Purchase Option** (HIPO) – This is State program that provides 18 months of extended health coverage to children under the age of 19 who are no longer eligible due to changes in income. (See 10-144 Code of Maine Regulations Chapter 335)

**Low Cost Drugs for the Elderly and Disabled** (DEL) – This is a State program that assists elderly or disabled individuals with the cost of their medications. (See 10-144 CMR Chapter 333)

**Maine Rx Plus** – This is a State program that assists Maine residents with the cost of their medications. Income guidelines are higher than under DEL and the benefit is less. See 10-144 CMR Chapter 334

**State Supplement to SSI** – This is a cash payment to SSI recipients and individuals who would otherwise be eligible for SSI except for income and citizenship criteria.

**Spousal Living Allowance** – This is a cash payment to a spouse of a resident of a Residential Care Facility or Cost Reimbursed Boarding Home. The spouse must meet income and asset criteria.

## SECTION 2 COVERAGE GROUPS AND ASSISTANCE UNITS

In order to be eligible for MaineCare an individual must fall within a category. Unless an individual qualifies for Medicaid under a Waiver Group or for the Medicare Buy-In, they must fall into one of the Categorically Needy/Medically Needy coverage groups. Each coverage group has specific eligibility criteria. Individuals can meet the eligibility criteria of more than one coverage group at the same time. Criteria can include age, pregnancy, responsibility for minor children, or disability, depending on the particular coverage group.

Once it has been determined that an individual meets the criteria of one or more coverage groups possible assistance units for each coverage group are identified.

An assistance unit is an individual or group enrolled in or applying for MaineCare. The assistance unit also includes individuals who are not covered or not applying for coverage but whose income and assets are considered in determining eligibility.

Individuals should be covered in the coverage group and assistance unit which is most beneficial for them. An individual can be included in more than one assistance unit at the same time in order to make sure that everyone who wants coverage gets coverage. When everyone who wants coverage cannot be covered and a decision needs to be made as to which family members will be covered, the individual must be informed of the coverage options and given the opportunity to choose which coverage is preferred.

Choosing a coverage group:

In a family with a parent claiming disability, the parent could be covered as SSI - Related (based on disability) or included with the rest of the family as Family - Related coverage if it provides the quickest decision.

Choosing an assistance unit:

In a family in which a child has countable income which would affect the eligibility of other family members, the child may be removed from the assistance unit. The child and any responsible relatives may then become members of a separate assistance unit. The responsible relative is also a member of the original assistance unit.

**Example:**
The family consists of a parent and two children. One of the children receives two hundred dollars a month in child support. The other child has

no income. The parent's earned income, in combination with the child support puts the assistance unit of the parent and the two children into a large deductible. However, an assistance unit of the parent and the child with no income can be considered. Only the earned income of the parent is used and the assistance unit size is two. The coverage group for the child with income is an assistance unit size of three (parent and both children) with the parent's earnings and the child support counted as income.

If an individual under age 21 wants coverage and the legal parents are on Temporary Assistance for Needy Families (TANF) that member's legal parent(s) must be included in the assistance unit with the individual. The parent's share of the TANF grant is countable income.

**Example:**
Ms. Soma gets a TANF benefit for herself and her 16 year old son. Her 19 year old also wants coverage. Ms. Soma, her income and her share of the TANF grant must be included in the assistance unit with the 19 year old. Alternatively, all three family members and their income including the TANF grant may be considered as one assistance unit.

If a family is getting the maximum grant, the share of the TANF grant attributed to the adult is the maximum grant amount for one adult. The share of the TANF grant attributed to the other members of the TANF filing unit including a second adult is determined by dividing the remaining grant amount by the number of other individuals in the TANF filing unit.

If the family has a TANF grant that is less than the maximum, the share attributed to each member of the TANF filing unit is the grant amount divided among the members of the filing unit.

## SECTION 3 CITIZENSHIP & IDENTITY

United States citizens are eligible to receive MaineCare benefits. An individual who is not a citizen of the United States may be eligible for full MaineCare benefits or they may be eligible for emergency benefits only.

### Section 3.1 Verification of Citizenship and Identity

I. Unless exempted below in II. A. through D., all members of a household applying for Medicaid and Cub Care (CHIP) must verify citizenship and identity. Failure to comply with this requirement will cause Medicaid and Cub Care ineligibility. For applicants and household members who cannot provide proof of citizenship and identity with their initial application, eligibility will be granted for 90 days, if all other eligibility factors are met. If the applicant does not provide documentation necessary to prove citizenship and identity of the applicant and household members within 90 days, benefits for unverified household members will be closed. This grace period will not be provided on subsequent applications submitted by or on behalf of the applicant or household members.

II. The following individuals are exempt from Citizenship and Identity requirements:

A. Medicaid and Cub Care applicants who receive either Supplemental Security Income (SSI) or Social Security benefits on the basis of disability, or Medicare.
B. People who receive child welfare assistance under IV-B of the Social Security Act or foster care assistance under IV-E of the Social Security Act. This exemption is for the child only, not the family providing the care.
C. A newborn whose mother receives Medicaid at the time of birth.
D. Pregnant women while covered under Presumptive Eligibility.

III. Failure to prove citizenship or alien status

A. Emergency Benefits only can be provided to an applicant unable to prove alien status. No Medicaid or Cub Care benefits can be provided to a citizen applicant unable to prove citizenship.
B. If an individual in a household is not eligible due to inability to prove citizenship, identity or alien status, the individual will still be counted as part of the household and that person's income and assets will be included in determining eligibility of the rest of the household.

## Section 3.2 Citizenship and Identity Requirements

I. Definition of Citizen. A citizen of the United States is:
A. an individual born in the United States or its territories, including Puerto Rico, the Virgin Islands, Guam, and the Northern Mariana Islands, except those born to a foreign diplomat, and who otherwise qualifies for U.S. citizenship under §301 *et seq*. of the Immigration and Nationality Act; [8 U.S.C. §§ 1401-1409].
B. an individual born of a parent who is a U.S. citizen or who otherwise qualifies for U.S. citizenship under §301 *et seq*. of the Immigration and Nationality Act; [8 U.S.C. §§ 1401-1409].
C. a naturalized citizen.
D. a national (both citizen and non-citizen national):
1. Citizen National. A citizen national is an individual who otherwise qualifies as a U.S. citizen under §301 *et seq*. of the Immigration and Nationality Act. [8 U.S.C. §§ 1401-1409].
2. Non-Citizen National. A non-citizen national is an individual who was born in one of the outlying possessions of the United States, including America Samoa and Swain's Island, to a parent who is a non-citizen national.

II. Primary Evidence of Citizenship and Identity

The following documents may be accepted as proof of both citizenship and identity because each contains a photograph of the individual named in the document, and the citizenship and identity of the individual have been established by either the U.S. or a state government. Primary verifications satisfy both citizenship and identity requirements:

A. U.S. passport, including U.S. passport card: a U.S. passport need not be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. However, a passport that was issued with limitation and is not currently valid may be used as proof of identity only. U.S. passports issued after 1980 show only

one person. However, spouses and children were sometimes included on one passport through 1980. The citizenship and identity of the included person can be established when one of these passports is presented.

B. Certificate of Naturalization (Department of Homeland Security form N - 550 or N-570);
C. Certificate of U.S. Citizenship (Department of Homeland Security form N-560 or N-561); or
D. Tribal enrollment documents, evidencing membership or affiliation with a Federally-recognized tribe.

III. Secondary Verifications of Citizenship

If primary verification from the list in previous paragraph (II.) is unavailable, the person should provide satisfactory documentary verification from paragraph (VI.) of this section to establish identity, and satisfactory verification of citizenship from the list below:

A. A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after 1/13/41), Guam, the Virgin Islands of the U.S., American Samoa, Swain's Island, or the Northern Mariana Islands (after 11/4/86 (NMI local time)). The birth record document may be issued by the state, commonwealth, territory or local jurisdiction. It must have been recorded before the person was 5 years of age. (A delayed birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship. See section V, paragraph B.
B. If the document shows the individual was born in Puerto Rico, Guam, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on the dates listed for each of the Territories. The following will establish U.S. citizenship for collectively naturalized individuals:
    1. Puerto Rico:
        a. evidence of birth in Puerto Rico and the person's statement that he or she was residing in the U.S., a U.S. possession, or Puerto Rico on 1/13/41; or
        b. evidence that the person was a Puerto Rican citizen and the person's statement that he or she was residing in Puerto Rico on 3/1/17 and that he or she did not take an oath of allegiance to Spain.
    2. U.S. Virgin Islands:
        a. evidence of birth in the U.S. Virgin Islands, and the person's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/27; or
        b. the person's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on 1/17/17 and residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on 2/25/27, and that the person did not make a declaration to maintain Danish citizenship; or
        c. evidence of birth in the U.S. Virgin Islands and the person's statement indicating residence in the U.S., a U.S. possession, or Territory or the Canal Zone on 6/28/32.

3. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands {TTPI}):
   a. evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on 11/3/86 (NMI local time) and the person's statement that s/he did not owe allegiance to a foreign state on 11/4/86 (NMI local time); or
   b. evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/81 (NMI local time), voter registration prior to 1/1/75 and the person's statement that s/he did not owe allegiance to a foreign state on 11/4/86 (NMI local time); or
   c. evidence of continuous domicile in the NMI since before 1/1/74 and the applicant's statement that s/he did not owe allegiance to a foreign state on11/4/86 (NMI local time).
   d. If a person entered the NMI as a nonimmigrant and lived in the NMI since 1/1/74, this does not constitute continuous domicile and the person is not a U.S. citizen.

C. A Certification of Report of Birth (DS-1350)

The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.

D. A Report of Birth Abroad of a U.S. Citizen (Form FS-240)

The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.

E. A Certification of Birth Issued by the Department of State (Form FS-545 or DS-1350)

Before 11/1/90, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.

F. A U.S. Citizen I.D. Card

This form was issued as Form I-197 until the 1980s by INS. INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until 4/7/83. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent

border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

G. A Northern Mariana Identification Card (I-873)

The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before 11/4/86. The card is no longer issued, but those previously issued are still valid.

H. An American Indian Card (I-872) issued by the Department of Homeland Security (DHS) with the classification code “KIC”

DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S. / Mexican border. A classification code of “KIC” and a statement on the back denote U.S. citizenship.

I. A final adoption decree showing the child's name and U.S. place of birth

In situations where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

J. Evidence of U.S. Civil Service employment before 6/1/76

The document must show employment by the U.S. government before 6/1/76. Individuals employed by the U.S. Civil Service prior to 6/1/76 had to be U.S. citizens.

K. U.S. Military Record showing a U.S. place of birth

The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth.)

L. A verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database. Inclusion in this database could prove citizenship through naturalization.

M. Evidence of meeting the automatic criteria for U.S. Citizenship outlined in the Child Citizenship Act of 2000.

N. Evidence of meeting the automatic criteria for U.S. citizenship under the provisions of the INA in effect on the person’s birthdate or adoption date, if the person’s birthdate or adoption date was prior to the Feb. 27, 2001 enactment date of the Child Citizenship Act of 2000 (citizenship laws are not retroactive, so the law applicable at the time the person was born or adopted applies, even if that law was subsequently repealed and replaced by a new section).

IV. Third-Level Verification of Citizenship

If verification from the lists in II and III of this section is unavailable and the person claims a U.S. place of birth, the person should provide satisfactory verification from paragraph (VI.) of this section to establish identity, and satisfactory verification of citizenship from the list below:

A. Extract of a hospital record on hospital letterhead, indicating a U.S. place of birth. The hospital record must have been established at the time of the person's birth and created five years before the initial application date for Medicaid or Cub Care. (For children under age 16, the document must have been created near the time of birth or five years before the date of application.) A souvenir "birth certificate" issued by a hospital does not satisfy this requirement.
B. Life, health, or other insurance record showing a U.S. place of birth. The record must have been created at least five years before the initial application date for Medicaid or Cub Care.
C. Religious record recorded in the U.S. within three months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. (Entries in a family bible are not considered religious records).
D. Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of the admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of the birth of the applicant's parents.

V. Fourth-Level Verification of Citizenship

If verification from the lists in previous paragraphs (II.,III.,and IV.) of this section is unavailable and the person claims a U.S. place of birth, the person should provide verification from paragraph (VI.) of this section to establish identity, and satisfactory documentary evidence of citizenship from the list below:

A. Federal or State census record showing U.S. citizenship or a U.S. place of birth. The census record must also show the applicant's age.

   Census records from 1900 through 1950 contain certain citizenship information. To secure this information, complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested". Also add that the purpose is for Medicaid and Cub Care eligibility.

B. One of the following documents that show a U.S. place of birth and was created at least five years before the application for Medicaid and Cub Care:
   1. Seneca Indian tribal census record;
   2. Bureau of Indian Affairs tribal census records of the Navajo Indians;
   3. U.S. State Vital Statistics official notification of birth registration;

4. A delayed U.S. public birth record that is recorded more than five years after the person's birth;
5. Statement signed by the physician or midwife who was in attendance at the time of birth; or
6. Bureau of Indian Affairs Roll of Alaska Natives.

C. Institutional admission papers from a nursing facility, skilled care facility or other institution, showing a U.S. place of birth, created at least five years before the initial application.

D. Medical (clinic, doctor, or hospital) record showing a U.S. place of birth. The record must have been created at least five years before the initial application date for Medicaid or Cub Care . (For children under age 16, the document must have been created near the time of birth or five years before the date of application).

An immunization record alone is not considered a medical record for purposes of establishing U.S. citizenship.

E. Written Affidavits of Citizenship

F. Declarations should only be used in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply:

1. There must be at least two affidavits by two people who have personal knowledge of the event(s) establishing the individual's claim of citizenship (the two affidavits could be combined in a joint declaration).
2. At least one of the people making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.
3. In order for the affidavits to be acceptable, the people making them must be able to provide proof of their own citizenship and identity.
4. If the people making the affidavits have information that explains why documentary evidence establishing the individual's claim of citizenship does not exist or cannot be readily obtained, the declaration should contain this information as well.
5. The applicant or recipient or other knowledgeable person (guardian or representative) must also provide an affidavit explaining why the evidence does not exist or cannot be obtained
6. The affidavits must be signed under penalty of perjury.

VI. Evidence of Identity

The following documents, even if expired, may be accepted as proof of identity and must be submitted when the person uses as proof of citizenship the documents listed in paragraphs (II.) through (V.) of this section. (A

separate document proving identity need not be submitted when the person submits Primary evidence of citizenship and identity as outlined in II. of this section):

A. A driver's license issued by a state or territory. The license must either have a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color.

**Note:** Individuals may not rely upon a Canadian driver's license, as the Centers for Medicare and Medicaid Services does not view this as a reliable form of identification.

B. School identification card. The card must have a photograph of the individual.

C. U.S. military card or draft record.

D. Identification card issued by the federal, state, or local government. The card must have the same information that is required for driver's licenses.

E. Military dependent's identification card.

F. Native American tribal document.

G. U.S. Coast Guard Merchant Mariner card.

H. Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document. The document must have a photograph or other personal identifying information relating to the individual.

**Note:** Individuals may not rely upon a voter's registration card, as the Centers for Medicare and Medicaid Services (CMS) does not view this as a reliable form of identification.

I. Three or more corroborating documents such as marriage licenses, divorce decrees, high school and college diplomas from accredited institutions, including general education and high school equivalency diplomas, property deeds or titles, and employer ID cards can be used to verify the identity of an individual.

**Note:** If the individual submitted fourth level verification of citizenship, three or more corroborating documents cannot be used to verify identity of the individual.

VII. Special Identity Rules for Children and some Disabled Individuals

A disabled individual in a residential care or institutional facility may have his or her identity attested to by the facility director or administrator when the individual does not have or cannot get any document on the preceding lists. Again, the affidavit is signed under the penalty of perjury, but need not be notarized.

Children under age 16 may have their identity documented using one of the following if none of the documents in paragraph (VI) are available:

A. school record including report card, daycare or nursery school record, verified by the Department with the issuing school.
B. clinic, doctor or hospital record.
C. an affidavit of identity. An affidavit of identity is only acceptable if it is signed under penalty of perjury by a parent, guardian, or caretaker relative stating the date and place of the birth of the child and cannot be used if affidavits were used to establish citizenship.

Identity affidavits may be used for children under age 18 in limited circumstances, when the child is from an area where a school ID with picture is not provided or a driver's license with a picture is not available.

VIII. Documentary Evidence

A. All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies will not be accepted. Originals or certified copies presented by the applicant or recipient will be returned whenever possible.
B. Copies of citizenship and identification documents shall be maintained in the case record or electronic data base.
C. Individuals may submit documentary evidence without appearing in person at an OFI office. Documents may be tendered in person, by mail, or by a guardian or authorized representative.
D. Presentation of documentary evidence of citizenship is a one-time activity; once a person's citizenship is documented and recorded in a state database, subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the person's citizenship.
E. The requirement to provide documentary evidence is the responsibility of the applicant. If documentation is not presented at application, the individual will be given a reasonable opportunity to provide the documentation.

## Section 3.3 Documentation and Verification for Non-Citizens

An individual who is not a citizen or national of the United States must present alien registration documentation, other proof of immigration registration from the U.S. Citizenship and Immigration Services (USCIS), or other documents indicating the individual's satisfactory immigration status. If documentation is not presented at application, the individual will be given a reasonable opportunity to provide the documentation. Temporary Medicaid coverage will not be provided if the applicant cannot provide satisfactory documentation of non-citizen status.

The Systematic Alien Verification for Entitlements Program (SAVE) is the U.S. Citizenship and Immigration Services (USCIS) operative system for verification of immigration status of aliens applying for MaineCare. Primary verification will be obtained through the Verification Information System (VIS). If no record is found, secondary verification procedures will be necessary. No eligible documented alien will be denied benefits based solely on information from VIS. Ineligibility

can be determined only following the secondary verification procedures in which a written request for verification is mailed to USCIS.

## Section 3.4 MaineCare Coverage for Non-Citizens

The Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 (PRWORA), P.L. 104-193, describes non-citizens as either qualified or non-qualified aliens. PRWORA further defines aliens who are eligible to receive either full benefit Medicaid or emergency benefits only, and qualified aliens who are subject to the five year bar from Medicaid eligibility.

An individual must provide documentation from the United States Citizen and Immigration Services (USCIS) to prove his or her immigration status.

If an individual admits to being an illegal (undocumented) alien, this information will not be shared with USCIS. All information is held confidential in accordance with Part 1, Section 2.

I. Non-Citizens Eligible for Full Benefits

Below is a listing of non-citizen groups who may be eligible for Full Benefits. See II. of this section for a listing of non-citizen groups who are eligible for Emergency Benefits Only.

| NON-CITIZEN STATUS | NECESSARY CHARACTERISTICS and CONDITIONS |
|---|---|
| 1.**Veteran or active duty personnel** | o Lawfully residing in U.S.; and<br>o A veteran of the U.S. Armed Forces with an honorable discharge or on active duty (not training) in the U.S. Armed Forces; or<br>o Lawfully residing in the U.S. and a spouse or unmarried child of the veteran described above. "Unmarried child": child is or could be claimed as dependent on veteran's tax return and meets MaineCare requirements for a dependent child. |
| 2. **Legal permanent resident** | o Legal permanent resident status granted under INA, 8 USC 1101 et seq.<br>**EXCEPTION:** Legal permanent residents are not eligible for full benefits if they have been in the U.S. less than five years. There is no five year waiting period if any of the following conditions applies:<br>• The individual's date of entry to the U.S. is prior to August 22, 1996;<br>• the individual is a child under the age of 21;<br>• the individual is a pregnant women;<br>• Prior to adjustment to legal resident status regardless of the LPR status granted date, the |

| | |
|---|---|
| | non-citizen's status was Refugee under §207, Asylee under §208, Person whose deportation was withheld under §243(h) or §241(b)(3) (#5 of this chart), Amerasian immigrant (#10 of this chart), or Cuban / Haitian entrant (#11 of this chart). This non-citizen is eligible as a Refugee, Asylee, Deportee, Amerasian immigrant, or Cuban / Haitian entrant (per Medicaid State Plan). |
| 3. **Refugee** | o Refugee status granted under §207 of the INA |
| 4. **Asylee** | o Asylee status granted under §208 of the INA |
| 5. **Deportation withheld** | o Deportee status granted under §243(h) of the INA as in effect prior to April 1, 1997; or §241(b)(3) of the INA, as amended |
| 6. **Parolee** | o Parolee status granted for at least a year under §212(d) (5) of the INA.<br>**EXCEPTION:** Parolees are not eligible for full benefits if they have been in the U.S. less than five years. There is no five year waiting period if one of the following conditions applies:<br>• The individual's date of entry to the U.S. is prior to August 22, 1996;<br>• the individual is a child under the age of 21;<br>• the individual is a pregnant woman |

| | |
|---|---|
| 7. **Conditional entrant** | o Conditional entrant status granted under §203(a)(7) of the INA in effect before April 1, 1980<br><br>**EXCEPTION:** Conditional entrants are not eligible for full benefits if they have been in the U.S. less than five years. There is no five year waiting period if one of the following conditions applies:<br>• The individual's date of entry to the U.S. is prior to August 22, 1996;<br>• the individual is a child under the age of 21;<br>• the individual is a pregnant woman |
| 8. **Battered non-citizen**<br>**OR**<br>**Battered Non-citizen's minor child** | o While lawfully residing in the U.S. the non-citizen or the minor child was battered or subjected to extreme cruelty by a spouse, a parent, or a member of the spouse's or parent's family residing in the same household as the non-citizen; and<br>o Batterer no longer lives in same household, and<br>o The non-citizen or the minor child meets the conditions set forth in §431(c) of PRWORA as amended (Section 431(c) of PRWORA, as amended, is codified at 8 USC 1641(c)).<br><br>**EXCEPTION:** Battered Non-Citizens are not eligible for full benefits if they have been in the U.S. less than five years. There is no five year waiting period if one of the following conditions applies:<br>• The individual's date of entry to the U.S. is prior to August 22, 1996;<br>• the individual is a child under the age of 21;<br>• the individual is a pregnant women |
| 9. **Trafficking Victim** | o Aliens certified as a trafficking victim (TV) under 107(b)(1) of the TV Protection Act of 2000, P.L. 106-386. |
| 10. **Amerasian** | o Admitted to the U.S. pursuant to §584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 |

| | |
|---|---|
| | |
| 11. **Cuban and Haitian Entrant** | o As defined in §501(e) of the Refugee Education Assistance Act of 1980 |
| 12. **American Indian born in Canada** | o The individual is at least one-half American Indian blood and provisions of §289 of the INA apply |
| 13. **Native American who is a member of a Federally-recognized Indian tribe** | o Member of an Indian tribe under section 4(e) of the Indian Self-Determination and Education Assistance Act |
| 14. **Iraqi Special Immigrant eligible under Public Law 110-161 and 110-181, Section 1244.** | o Has same status as refugee under 2009 Department of Defense Bill. |
| 15. **Afghani Special Immigrant eligible under Public Law 110-161.** | o Has same status as refugee under 2009 Department of Defense Bill. |
| 16. **Lawfully residing pregnant women, and children under the age of 21.** | Under the Children's Health Insurance Program Reauthorization Act of 2009, Section 214, lawfully residing pregnant women and children under the age of 21 include:<br><br>(1) A "Qualified alien" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;<br><br>(2) A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside |

| | |
|---|---|
| | permanently or indefinitely in the U.S.;<br><br>(3) An individual described in 8 CFR section 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:<br>(a) An individual currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);<br>(b) An individual currently under protected Status pursuant to section 244 of the INA;<br>(c) A family Unity beneficiary pursuant to section 301 of Public Law 101-649 as amended by, as well as pursuant to, section 1504 of Public Law 106-554;<br>(d) An individual currently under Deferred Enforced Departure pursuant to a decision made by the President; and<br>(e) An individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and<br><br>(4) An individual in non-immigrant classifications under the INA who is remain in the U.S. for an indefinite period, including the following as specified in section 101(a)(15) of the INA:<br>• A parent or child of an individual with special immigrant status under section 101(a)(27) of the INA, as permitted under section 101(a)(15)(N) of the INA;<br>• A Fiancé of a citizen, as permitted under section 101(a)(15)(K) of the INA;<br>• A religious worker under section 101(a)(15)(R);<br>• An individual assisting the Department of Justice in a criminal investigation, as permitted under section 101(a)(15)(S) of the INA;<br>• A battered alien under section 101(a)(15)(U) (see also section 431 as amended by PRWORA); and<br>• An individual with a petition pending for 3 years or more, as permitted under section 101(a)(15)(V) of the INA. |

II. Non-Citizens Eligible for Emergency Benefits

A non-citizen who has no USCIS documents regarding his or her alien status, or who is an ineligible alien as defined below, or who is a qualified alien subject to the five year waiting period for full Medicaid can get Medicaid

or Cub Care (CHIP) Emergency Benefits only. Individuals must still meet income and asset tests, and must be in a coverable group. These individuals must meet all basic eligibility requirements (including Maine residency) with the exception of citizenship or alien status and providing a Social Security number. If it is determined that any of the above individuals intend to remain in Maine at the time of application they will be considered Maine residents.

MaineCare will only cover Emergency Benefits for the non-citizen groups listed in the chart below:

| NON-CITIZEN STATUS | NECESSARY CHARACTERISTICS and CONDITIONS |
|---|---|
| 1. **Undocumented alien** | o Non-qualified aliens who do not have USCIS documentation of their citizenship status. |

| | |
|---|---|
| 2. **Ineligible alien** | o Non-qualified aliens legally admitted on a temporary basis or for a specific period of time. The following are examples of individuals who are ineligible aliens:<br><br>A. foreign government representatives on official business and their families and employees;<br>B. visitors for business or pleasure, including exchange visitors;<br>C. aliens in travel status while traveling directly through the United States;<br>D. crewmen on shore leave;<br>E. treaty traders and investors and their families;<br>F. foreign students;<br>G. international organization personnel and their families and servants;<br>H. temporary workers, including agricultural contract workers; and<br>I. members of foreign press, radio, film or other information media and their families<br>J. Parolee in the U.S. under Section 212(d)(5) for less than one year<br><br>**NOTE:** Except for J. above these aliens should have one of the following types of INS documents: Form I-94, Arrival-Departure Record; Form I-185, Canadian Border Crossing Card; Form I-186, Mexican Border Crossing Card; Form SW-434, Mexican Border Visitor's Permit; Form I-95A, Crewman's Landing Permit; or Form I-184, Crewman's Landing Permit and Identification Card.<br><br>**EXCEPTION:** Some ineligible aliens may be included for full coverage under CHIPRA 2009, Section 214. Lawfully residing pregnant women and children under age 21 may be eligible for full benefits—refer to #16 in the previous chart of this section, “Non-Citizens Eligible for Full Benefits.” The term “lawfully residing” includes nonqualified aliens who are in the U.S. lawfully. |

| | |
|---|---|
| 3. **Qualified Alien Subject to the Five Year Waiting Period** | o Qualified aliens who enter the United States on or after August 22, 1996 are subject to a five year waiting period for full Medicaid unless they are specifically exempt from this waiting period or otherwise included in the State Medicaid Plan.<br><br>o As indicated in Section 3.4, I, the following qualified aliens are not subject to the five year waiting period:<br><br>A. Qualified Aliens who came to the United States before August 22, 1996<br>B. Legal Permanent Residents whose prior qualified alien status was Refugee, Asylee, Person whose deportation was withheld, Amerasian immigrant, Haitian entrant, or Cuban entrant.<br>C. Pregnant women<br>D. Children under the age of 21<br>E. The following Qualified Aliens:<br>• Veteran or Active Duty Personnel<br>• Refugee<br>• Asylee<br>• Deportation Withheld<br>• Trafficking Victims<br>• Amerasians<br>• Cuban and Haitian Entrants<br>• American Indian born in Canada<br>• Native Americans who are members of Federally-recognized Indian Tribes<br>• Iraqi Special Immigrants<br>• Afghani Special Immigrants<br><br>• Immigrants who entered the United States prior to August 22, 1996 and did not remain "continuously present" in the U.S. until becoming a qualified alien on or after that date are also subject to the five year waiting period. Any single absence of more than 30 consecutive days or a combined total absence of 90 days before obtaining qualified alien status interrupts "continuous presence."<br><br>• The five year waiting period begins on the date the immigrant obtains qualified alien status. Once the five year expires, the qualified alien is eligible for full Medicaid benefits. |

**SECTION 4 RESIDENCY**

Each individual must be a resident of Maine. A resident is an individual living in the State of Maine with the intent to remain indefinitely.

An individual who is visiting or in Maine temporarily is not a resident. The individual should apply to the actual state of residence for Medicaid. However, if the individual is living in Maine and has entered the State with a job commitment or seeking a job (even if only a temporary job, e.g., migrant workers), the individual is a resident of Maine.

When two or more states cannot resolve which state is the state of residence, the state where the individual is physically located is the state of residence for Medicaid purposes.

Eligibility cannot be denied or terminated because:

I. an individual has not resided in the State for a specified period;

II. the individual did not establish residence before entering a medical institution; or

III. an individual is temporarily or involuntarily absent from the State, provided the individual intends to return once the purpose of the absence has been accomplished, unless another state has determined the individual is a resident there.

Eligible individuals who move out of Maine and intend to remain out of state and are making application for assistance in that state remain eligible until the other state determines eligibility or ineligibility.

**Section 4.1 Children**

For purposes of residency a child is any individual under the age of 21. A dependent child is a resident of the state where the caretaker relative resides. An independent child is a resident of the state where they reside with an intent to remain indefinitely.

**Section 4.2 Title IV-E of the Social Security Act**

In any situation where a child is eligible for a Title IV-E payment (including the Federal Adoption Assistance Program) from another state, the state of residency, for Medicaid purposes, is the state in which the child is physically living (See Part 3, Section 4.5.2). Children who are receiving services under the Interstate Compact for the Placement of Children (ICPC) who are not receiving Title IV-E payments from another state are not considered residents of the State of Maine.

**Section 4.3 Residents of Medical Institutions**

I. If a state arranges for an individual to be placed in an institution located in another state, the state making the placement is the individual's state of residence, regardless of the individual's indicated intent or ability to indicate intent.

II. For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is that of the individual's parents, or legal guardian. If the parents reside in separate states and there is no

appointed legal guardian, the state of residence is that of the parent applying for Medicaid on the individual's behalf.

III. For an institutionalized individual who became incapable of indicating intent on or after age 21, the state of residence is the state in which the individual was living when the individual became incapable of indicating intent.

IV. The state where the institution is located is the individual's state of residence unless that state determines that the individual is a resident of another state by applying the rules under (I.) or (II.) above.

V. For any other institutionalized individual, age 21 or over, the state of residence is the state where the individual is living with the intention to remain for an indefinite period of time.

An individual is considered incapable of indicating intent if:

I. the individual has an I.Q. of 49 or less or has a mental age of 7 or less based on tests acceptable to the Office of Adults with Cognitive and Physical Disabilities (OACPD);
II. the individual has been judged legally incompetent; or

III. medical or other acceptable documentation supports a finding that the individual is incapable of indicating intent.

**Section 4.4 SSI and State Supplement Recipients**

An individual who is receiving SSI or State Supplemental payments is considered a resident of the state making the payment.

## SECTION 5 SOCIAL SECURITY NUMBERS

All individuals are asked to provide their Social Security Number.

All individuals are required to have a Social Security number or proof of application with the exception of:

I. undocumented non-citizens; or

II. a child who is born to a mother covered by Medicaid at the time of their birth. By the time the child turns one an application for or proof of a Social Security number must be provided.

The individual is required to furnish the Department with a Social Security number. If the individual has a Social Security number but is unable to provide it, the Department must contact the Social Security Administration in order to obtain the number.

The individual is required to apply to the Social Security Administration for a Social Security number if the individual does not have a Social Security number. The applicant or recipient must provide the Department with verification that the application for a Social Security number has been made. The Social Security number will be provided by the Social Security Administration.

For a child born to a mother not covered by Medicaid at the time of the child's birth, the Social Security number requirement must be met by the first day of the second month following the month in which the child's mother is discharged from the hospital.

**Examples:**

1. A child is born on July 3rd. Mother leaves the hospital on July 6th. Application for a Social Security number for the child must be completed by September 1st.
2. A child born on July 31st. Mother leaves the hospital on August 2nd. Application for a Social Security number for the child must be completed by October 1st.

The Eligibility Specialist should explain that the Social Security Administration requires the individual to provide a valid birth certificate or other proof of age and verification of identity.

The Department must assist the individual in obtaining verification necessary to apply for a Social Security number. This includes obtaining documents to prove date of birth, citizenship or identity if these materials cannot be provided by the individual. The Department cannot pay any costs incurred in obtaining this information.

MaineCare will not be withheld or terminated for lack of a Social Security number as long as an individual provides verification of application for a Social Security number for those requesting assistance. MaineCare will not be withheld or terminated while verification of the individual's Social Security number is being obtained from the Social Security Administration.

## Section 5.1 Non-Compliance/Sanctions/Good Cause

For any individual who fails to provide or apply for a Social Security number as required, Medicaid and/or Cub Care must be denied or terminated.

When the Social Security number requirements for a dependent child are not met the parent or specified relative as well as the child must be denied or terminated for Medicaid and/or Cub Care.

I. When an individual is not eligible for Medicaid and/or Cub Care the individual is included in the assistance unit size and the individual's income and assets are used to determine eligibility for the assistance unit.

II. When a stepparent must be sanctioned, the stepparent's income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Levels (See Chart 6).

III. When a specified relative other than a parent or stepparent must be sanctioned, the specified relative's income and assets are considered in the same manner as a sanctioned parent's. However, such sanctioned specified relative may choose to be excluded from the assistance unit.

An individual may request good cause for not providing a Social Security number. See Section 8 of this Part for specific information regarding good cause.

**Section 5.2 Retroactive Coverage**

If otherwise eligible, retroactive coverage will be granted if the Social Security number requirements are met during the application process. If the Social Security number requirements are not met, but at a later date the individual cooperates with these requirements, the retroactive coverage cannot be granted.

**Examples:**

1. A parent refuses to apply for a Social Security number for a child. The parent and the child are denied coverage. One month later, the parent agrees to comply. The parent and child are eligible, effective the first day of the month in which the application for a number is made. Retroactive coverage cannot be granted.

2. A parent refuses to apply for a Social Security number. Coverage for the parent only must be denied. A year later, the person reapplies and gives a Social Security number proving application for the number was made six months previously. Eligibility may be authorized with up to three months' retroactive coverage because the applicant complied with the Social Security number requirements prior to the retroactive period.

Individuals must be informed that the Social Security number will be utilized in the administration of MaineCare and will be used for verification of information such as wages, unemployment benefits and bank accounts.

**SECTION 6 ASSIGNMENT OF RIGHTS TO MEDICAL PAYMENTS (referral to the Third Party Liability Unit (TPL))**

As a condition of eligibility for Medicaid and Cub Care, certain individuals must assign to the Department of Health and Human Services their rights to payment for medical care from any third party and cooperate in obtaining these medical payments. This is done by a referral to TPL.

**Section 6.1 Who must comply:**

I. Parents or other specified relatives applying on behalf of themselves and their children;

II. individuals age 18 or over who are applying on their own behalf; and

III. individuals under age 18 who are applying on their own behalf who are married or in the military.

This provision does not apply to pregnant women.

**Section 6.2 What is required:**

I. Assign rights to payment for medical care;

II. cooperate with the Third Party Liability Unit in obtaining medical payments; or

III. relinquish medical payments received directly from a third party resource which were intended to cover services paid by Medicaid.

IV. Items for both prospective and retroactive periods, which must be reported include:
   A. any court ordered responsibility to pay medical bills by a parent, unless it can be demonstrated that contact with the parent by the Third Party Liability Unit (TPL) or Division of Support Enforcement and Recovery (DSER) could cause harm;
   B. medical insurance (except Medicare) covering the applicant or recipient. This includes private medical group insurance, TRICARE (formerly CHAMPUS), and supplemental policies such as companion plans from Blue Cross/Blue Shield, Major Medical and indemnity insurance. Reporting is required whether the cost of premiums is paid by the individual, employer, or another person;
   C. the portion of Worker's Compensation benefits for medical services for which the recipient is applying, receiving, or which terminated during the retroactive eligibility period; and
   D. information regarding settled or pending lawsuits involving personal injury.

**Section 6.3 Non-compliance:**

I. If an individual who is required to do so fails to comply with these provisions, Medicaid is denied or terminated. An individual who does not comply with this requirement is not eligible for Medicaid. When parents or other specified relatives are applying on behalf of themselves and their children, it is the parent or other specified relative applying on behalf of the child under age 18 who is not eligible, not the child.

II. When an individual is not eligible for Medicaid because they do not comply with the provisions to apply for a Social Security Number, cooperate with the Division of Support Enforcement and Recovery (DSER) or cooperate in a referral to TPL, the individual is counted in the assistance unit size and the individual's income and assets are used to determine eligibility for the assistance unit.

III. When a stepparent must be sanctioned, the stepparent's income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Level (See Chart 6).

IV. When a specified relative other than a parent or stepparent must be sanctioned, the specified relative's income and assets are considered in the same manner as a sanctioned parent's. However, such sanctioned specified relative may choose to be excluded from the unit.

An individual may request good cause for non-compliance with TPL. See Section 8 of this Part for specific information regarding good cause.

## SECTION 7 COOPERATION IN OBTAINING MEDICAL SUPPORT FROM THE NON-CUSTODIAL LEGAL PARENT AND ESTABLISHING PATERNITY

**Section 7.1 Who Must Comply**

Certain individuals must cooperate in obtaining medical benefits from the non-custodial parent of a dependent child (See Part 3, Section 1) and in establishing paternity. If the individual can show that good cause for not cooperating exists, no referral will be made.

These individuals are parents or other specified relatives applying on behalf of themselves and their children unless the assistance unit is being covered under Transitional Medicaid.

This provision does not apply to pregnant women or individuals covered under Transitional Medicaid. An individual who does not comply with this requirement is not eligible for Medicaid. It is the parent or other specified relative applying on behalf of the child under age 18 who is not eligible, not the child.

**Section 7.2 What is Required:**

I. Identify and help locate those parents of a dependent child for whom Medicaid is requested.

II. Cooperation includes responding to requests for information from DSER and appearing as a witness at a judicial or other hearing or proceeding.

**Section 7.3 Non-Compliance:**

I. If an individual who is required to do so fails to comply with these provisions, Medicaid is denied or terminated.

II. When an individual is not eligible for Medicaid because they do not cooperate with DSER the individual is included in the assistance unit size and the individual's income and assets are used to determine eligibility for the assistance unit.

III. When a stepparent must be sanctioned, the stepparent's income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Level (See Chart 6).

IV. When a specified relative other than a parent or stepparent must be sanctioned, the specified relative's income and assets are considered in the same manner as a sanctioned parent's. However, such sanctioned specified relative may choose to be excluded from the assistance unit.

An individual may request good cause (See Section 8 of this Part) for non-compliance with TPL.

**SECTION 8 GOOD CAUSE**

Every Medicaid or Cub Care applicant or recipient will have the opportunity to claim good cause for refusing to cooperate. When the individual claims good cause,

sanctions will not be implemented unless it is finally determined that good cause does not exist.

Cooperation requirements, sanctions, and the right to claim good cause must be explained to the individual. The Eligibility Specialist must inform the individual that DSER may attempt to establish paternity and collect medical support in cases where there is no risk to the individual or children.

If the individual thinks that attempts to establish paternity or collect support would pose a risk to the individual or children, the individual must provide evidence to substantiate the claim of good cause not to cooperate.

The Eligibility Specialist must document the reasons for granting or denying the claim of good cause and must notify the individual of the decision in writing. If the decision is not to grant good cause, the individual must be given the opportunity to withdraw from the Program or provide additional information to substantiate the claim. The Eligibility Specialist makes the final determination of good cause.

The individual's eligibility will be determined prior to granting or denying good cause. Referral of the parent who is not in the home to TPL will not be made while the decision is pending. If good cause is granted, no referral will be made.

If good cause is not granted and the individual continues to refuse to cooperate, sanctions will be applied and the TPL unit and DSER will proceed without the individual's cooperation.

The Eligibility Specialist must discuss the above with the individual at the time of the application.

Good cause for not cooperating may be claimed by the individual if the individual can demonstrate that:

I. cooperation may reasonably be anticipated to result in physical or emotional harm to the child or physical or emotional harm to the caretaker relative which would hinder the ability to care for the child.

II. legal proceedings for adoption of the child are pending before a court or the individual has been working with a social agency to decide whether to relinquish the child for adoption.

III. the child was conceived as the result of rape or incest.

Documents from court records, law enforcement agencies, medical sources, social service agencies and any other legal document may be used to substantiate rape, adoption and physical or emotional harm to the child or caretaker relative. If such documents are unavailable, information may be secured from other sources familiar with the claims of the individual. The Agency should assist the individual in obtaining the required evidence, but no contact with collateral sources will be made without the individual's knowledge and consent.

A contact with the absent parent or putative father should be made only if it is essential to the claim for good cause. Contact should not be made until the applicant or recipient has the opportunity to:

I. present additional evidence or information which makes contact with the absent parent or putative father unnecessary;

II. withdraw the application for assistance, or have the case closed; and

III. have the good cause claim denied.

## SECTION 9 INDIVIDUALS RESIDING IN PUBLIC INSTITUTIONS

I. Medicaid coverage is authorized for inmates of state prisons, Mountain View Youth Development Center, Long Creek Youth Development Center, local or county jails, if the individual meets financial and non-financial criteria applicable to non-inmates. Medicaid will only pay for any coverable in-patient service provided to the inmate while they are an in-patient in a hospital, nursing home, intermediate care facility for the mentally retarded (ICF/MR) or juvenile psychiatric facility.

II. Individuals admitted to reside in a public (or private) medical institution classified as an IMD (Institution for Mental Disease) for over thirty days: Spring Harbor, Acadia, Riverview Psychiatric Center, and the Dorothea Dix Psychiatric Center. The following applies:
   A. if over age 20 and under age 65, these individuals are not Medicaid eligible until they are conditionally or unconditionally released or are on convalescent leave from the facility. Individuals may apply prior to discharge, but eligibility is not granted until they are released or are on convalescent leave.
   B. if under age 21 (through age 20) or age 65 or over, coverage is available for all Medicaid coverable services.

## SECTION 10 APPLICATION FOR OTHER BENEFITS

Individuals must take all appropriate steps to obtain benefits to which they are entitled. This includes applying for the benefit and providing the other benefit source with necessary information to determine eligibility for the benefit.

I. Other benefits for which the individual must file include Social Security, Railroad Retirement, Veteran's Pension/ Compensation, Worker's Compensation, and Unemployment Insurance. This provision does not apply to SSI, State Supplement, TANF cash benefits and other Federal, State, local or private programs which make payments based on need.

II. Individuals who apply for Medicaid and DEL and who are eligible for Medicare Parts A, B and/or D must be enrolled in or take action to enroll in these programs and a Medicare Part D Prescription Drug Plan at the next available opportunity to do so.

III. Individuals who are enrolled in Medicaid and DEL and subsequently become eligible for Medicare Parts A, B and/or D must be enrolled in or take action to enroll in these programs and a Medicare Part D Prescription Drug Plan at the next available opportunity to do so.

IV. There is good cause for not enrolling in Medicare and/or Medicare Part D Prescription Drug Plan if:

A. the individual is not eligible for Medicaid and DEL to pay any premiums and cost sharing for Medicare Parts A and/or B as described in Part 8.
B. the individual is denied enrollment by Medicare or by a Medicare Prescription Drug Plan due to circumstances beyond his/her control or,
C. the individual has prescription drug coverage which is determined by the insurer to be creditable coverage. Creditable coverage means that the coverage on the average is at least as good as the standard Medicare Prescription drug plan.
D. enrollment is not cost effective as determined by the Pharmacy Benefits Manager.

V. Do not require an individual:
A. to file for other benefits when applying for them would result in no additional benefit which affects the individual's eligibility.
B. to pursue a claim for other program benefits through the appeals process.
C. who is not applying for or covered by Medicaid to pursue a claim for other program benefits, for example, an ineligible spouse, parent or child.

## SECTION 11 APPLICATION PROCESS

An application is a signed request for MaineCare coverage. This request must be made on a document approved by OIAS as an application form.

The individual or someone acting on the individual's behalf may sign the application form. The applicant may choose anyone to help in completing the form.

The date of application is the date the signed application form is received in any OIAS office. For presumptive eligibility for pregnant women, the date the form is signed and dated by both the applicant and the designated person at specified provider sites is considered the date of application (See Part 3, Section 4.3.1).

All signed applications will be acknowledged in writing. A written decision of eligibility will be sent to the applicant.

An application which is denied is valid for the month of application and the following month.

**Example:**
An individual applies in January seeking prospective coverage. They exceed the asset limit for January. The application is denied for prospective coverage. In February, the individual verifies that assets are below the asset limit and requests prospective coverage. Prospective coverage may be granted beginning February 1st. It is not necessary for the individual to complete another application form.

### Section 11.1 Subsequent requests for eligibility

Once eligible for MaineCare, the Food Supplement Program, or TANF/PaS an individual does not need to complete a new application form if:

I. open for the Food Supplement Program (FSP) and wants MaineCare. In this situation the application date is the date that the request is made, either orally or in writing. Additional information may still be needed to determine eligibility.

II. open MaineCare and requesting eligibility for new members orally or in writing. The application date for the new member is the date the request is made. Additional information may still be needed to determine eligibility.

III. open under one MaineCare program (for example Medicaid) and requesting coverage under another MaineCare program (for example Buy-in). In this situation the application date is the date that the request is made, either orally or in writing. Additional information may still be needed to determine eligibility.

IV. open MaineCare and now requesting coverage in a facility or Home and Community Based Waiver services. Additional information may still be needed to determine eligibility.

V. SSI recipients moving to a residential care facility where SSI benefits continue. Additional information may still be needed to determine eligibility.

SSI Individuals who move to a nursing facility need to complete an application. Community coverage is to be kept open while determining eligibility in the facility.

All applicants or re-applicants for MaineCare will be given information in writing, or verbally if appropriate, about the following:

I. services covered under MaineCare;

II. conditions of eligibility;

III. the individual's rights, including the right to an Administrative Hearing;

IV. responsibilities of recipients, including reporting changes within ten days (See Section 12.2 of this Part); and

V. the 45-day application processing standard (See Section 12.3.1 of this Part).

A reapplication is any signed application form received after the Adverse Action Notice Period. This includes review forms returned after that period.

**Section 11.2 Recipients of SSI or State Supplement**

Aged, blind or disabled individuals and couples who are recipients of SSI or State Supplement are automatically covered as Categorically Needy unless they refuse to assign their rights to payments for medical care. A separate application for Medicaid (including coverage for any Home and Community Based Waiver program) is not needed for these groups.

## SECTION 12 CLIENT AND AGENCY RESPONSIBILITIES

**Section 12.1 Verification of Eligibility Factors**

The individual or the individual's representative is responsible for supplying verification of information for all persons in the household whose circumstances

affect eligibility. If this information is not provided, eligibility does not exist. It is the responsibility of the Department to assist the individual in establishing eligibility for MaineCare**.**

Verification of information needed to determine eligibility must be requested initially from the individual. If information is requested from other sources (with the exception of public records) the individual must be informed. If collateral contacts are necessary to determine eligibility and the individual does not give consent, denial or closure must occur because the Department is unable to determine eligibility.

When a decision cannot be made due to inconclusive or conflicting information, the individual will be notified what questions remain and what needs to be resolved. If the Department cannot determine that eligibility exists after contacting the individual or collateral contacts, assistance will be denied or closed.

**Section 12.2 Reporting Responsibilities**

Changes which are expected to occur before the next review must be explored by the Eligibility Specialist.

The Eligibility Specialist should discuss any potential changes in family size, assets, residency, income (for example, unemployment, Social Security, Worker's Compensation or a new job), school attendance, disability, and ages of covered members (to determine if changes in coverage will occur because of age).

It is the responsibility of the individual to report changes of income, assets, household composition and any other change in circumstances which affect eligibility for MaineCare. Such change is to be reported within ten days from occurrence. For income purposes, "occurrence" will be considered the date the increased income was received. For all other purposes, "occurrence" will be considered the date the change took place. Applicants and recipients are informed of reporting responsibilities in the notice of eligibility.

Eligibility will be recalculated within thirty days of the receipt of new information which may affect the level of MaineCare coverage or cause ineligibility

**Section 12.3 Temporary Coverage**

**Section 12.3.1 Forty Five (45) Day Processing Standard**

The applicant must be sent a notice of eligibility no later than forty-five days after the date of application. The 45-day processing standard is the result of the settlement of a court case, Polk et al. vs. Longley. The consent decree stated that all applications must be acted upon and a decision made as quickly as possible.

Temporary Coverage is Medicaid coverage that is authorized because an application has not been processed timely.

If the individual is over income guidelines a deductible needs to be met prior to temporary coverage being granted.

I. Temporary Coverage is authorized when:
   A. a decision is not made within forty-five days. The Department must authorize temporary coverage. This provides Medicaid coverage from day forty-six until a final decision is made on the application.

B. it is necessary to obtain medical reports from physicians, hospitals, or other medical sources and such medical information is not requested from all necessary sources within five days after the date of application. If the reports are not received within fifteen days of the first request, a second request must be sent. The applicant is to be notified whenever a second request is made to inform the individual that the necessary medical reports have not been received.
C. a deductible is met. Temporary Coverage will be authorized the later of the 46th day or the date the deductible is met.

II. Temporary Coverage will not be authorized if:
A. there is documentation that the applicant or the applicant's source of medical information has not cooperated in obtaining information necessary to make a decision. Documented non-cooperation by the applicant or the source of the applicant's medical information means that the case record must contain sufficient information to show that the applicant or the source of the applicant's medical information was requested to provide specific information or verification, or carry out particular activities necessary to establish eligibility and that the applicant or medical source failed or delayed in doing so within a reasonable period of time.
B. the individual must meet a deductible and the deductible has not yet been met.

### Section 12.3.2 Ten (10) day processing standard for deductibles

The consent decree filed as a result of Polk et al. vs. Longley also mandates that the Department issue a medical card no later than ten days after the applicant furnishes adequate information about incurred medical expenses in order to meet the deductible. Adequate information includes the date, cost, type of service and amounts payable by insurance and other third parties for submitted bills.

If the person is not issued a medical card within ten days of submitting the information, the Eligibility Specialist must issue temporary coverage, effective on the 11th day unless there is documentation that the individual is not cooperating.

### Section 12.3.3 Ending of Temporary Coverage

If the individual is found to be eligible, Medicaid coverage will go back to the first month of eligibility. This could be a retroactive month, the month of application or the first day of eligibility when a deductible to met.

If the applicant is found to be ineligible after temporary coverage has been issued, the applicant is to be sent a notice of denial. There is no Adverse Action Notice Period. The applicant becomes ineligible upon the receipt of the denial notice (three days from the day the notice is mailed). In no instance may the dates of temporary coverage be eliminated. The individual may request a hearing regarding the denial, but coverage will not continue pending the hearing decision. If the decision of the Hearing Officer is to remand the case back to the regional office for a new decision, temporary coverage is reinstated back to the date that the coverage stopped.

No payment for medical services provided to the individual during the period when the applicant was eligible for temporary coverage is recoverable from the applicant.

## SECTION 13 ELIGIBILITY PERIODS/REVIEWS

An individual's eligibility period is based on the month the application is received. Eligibility for the prospective period is determined for twelve months for all MaineCare programs with the exception of:

- six months for Medically Needy
- twenty-four months for DEL and Maine Rx

The eligibility period begins on the 1st day of the month of application unless temporary coverage is being given. (See "45 Day Processing Standard", Section 12.3.1 of this Part). In some instances, the individual is not eligible for coverage during the month of application but is eligible for the following month (See Section 11 of this Part). In this situation, the length of the eligibility period remains the same (six, twelve or twenty-four months), depending on the type of coverage.

A review is a re-determination of eligibility. Appropriate review forms must be used. If the recipient is no longer eligible an Advance Notice must be sent. If the review form is not received in a regional office by the end of the month in which the Adverse Action Period ends, (See Section 15 of this Part) it is considered a reapplication.

## Section 13.1 Changes within the Eligibility Period

Changes reported by recipients during the eligibility period must be reviewed by the Eligibility Specialist to determine the effect of the change on the individual's eligibility.

If the new information results in a change in the level of coverage, the Eligibility Specialist must give the recipient timely and adequate notice of the change of level or termination in coverage (See Section 15 of this Part).

Certain categorically eligible individuals have a continuous period of eligibility even if changes occur. These groups are:

I. Newborns -

If the newborn's mother is receiving Medicaid (or is covered as part of the retroactive period) on the date the baby is born, the baby is eligible regardless of the income of the assistance unit. The mother must be fully covered by Medicaid on the day of the baby's birth. In other words, if mother meets the deductible amount on the day of the baby's birth and is partially responsible for any medical bills on that date, the newborn is not eligible in this group.

Coverage continues for one year. This means that the baby is eligible without regard to changes in income or composition of the assistance unit.

II. Children under age 19 -

Any categorically eligible child (including a newborn) who is;

A. not in the Katie Beckett group; and
B. under the age of 19 (through the end of the month of his or her 19th birthday) is continuously eligible for full benefits for twelve months after eligibility is determined by application or review (beginning with the month of application or review) without regard to changes in

income or composition of the assistance unit. Eligibility within the twelve month period will end if:

1. at the end of the month the child turns 19;
2. when the child ceases to be a state resident; or
3. when mail addressed to the child or child's household is returned as undeliverable.

A child who becomes eligible for Transitional Medicaid at the time of annual review does not get twelve months of continuous eligibility.

**Examples:**

1. Family reviewed 1/08 and is found eligible for Transitional Medicaid effective 2/08. Based on their TM report they are over income for the second 6-month period. The children do not have continuous eligibility through 1/09.

2. Family reviewed 1/08 and found eligible Family -Related Section 1931 effective 2/08. A change moves the family into Transitional Medicaid effective 4/08. Based on their TM report they are over income for the second 6-month period. The children have continuous eligibility through 1/09.

If a child is receiving coverage based on eligibility for SSI or State Supplement benefits or under an SSI - Related coverage group, the child's Medicaid coverage continues for twelve months even if the SSI, or State Supplement benefit ends.

When SSI or State Supplement benefits end before the conclusion of the twelve month eligibility period, the child's coverage continues and a review is done for month twelve.

The Medicaid review after an SSI closing is the start of a twelve month eligibility period.

**Example:**
A child is eligible as SSI - Related in 12/07. The child is found to not meet the disability criteria in 7/08. Medicaid continues through 11/08 when a review of eligibility is completed.

III. Pregnant women -

Once granted, pregnant women are continuously eligible for sixty days beyond the date the pregnancy ends and through the last day of the month in which the 60$^{th}$ day falls.

**Section 13.2 Medically Needy Eligibility Periods**

Medically Needy recipients have a six month eligibility period. Most have to meet a deductible to gain eligibility. The only time the six month deductible period is shortened is in situations when:

I. the individual, age 20, will turn 21 in less than six months;

II. the individual dies;

III. the individual becomes eligible for coverage in nursing care status; or

IV. the individual voluntarily withdraws from the program. If the individual voluntarily withdraws and reapplies, new deductible periods (both retroactive and prospective) are established based on the new application. Some months of the retroactive coverage possible from the first application may not be included in the new retroactive period which is established with the reapplication.

Medically Needy coverage begins on the day of the month that the deductible is met. The individual may have some responsibility for bills for medical services incurred on that day. If there is no deductible or the deductible is met with uncovered items, coverage begins on the first day of the month of eligibility.

Once the date of eligibility is established, unless there is a change in income which changes the deductible amount or the individual becomes ineligible for Medicaid, coverage continues to the end of the deductible period. These individuals are entitled to review and advanced notice as described in Section13 above.

Although individuals who are eligible for Medically Needy coverage are in a deductible for six months, if their income is stable and is between the Categorically Needy income levels and the Protected Income Level (PIL) – (See Chart 5), a complete review is necessary once every twelve months rather than once every six months.

**Section 13.3 Changes within the Medically Needy Eligibility Period**

All changes reported by the recipient during the six month eligibility period must be reviewed by the Eligibility Specialist to determine the effect of the change on the individual's eligibility.

If the new information results in a change in the level of coverage, the Eligibility Specialist must:

I. give the recipient timely and adequate notice of the change of level or termination in coverage (See Section 15 of this Part);

II. determine the effect of the new information on the amount of the deductible; and

III. allow the individual to withdraw and reapply if the information would result in a change of coverage to Categorically Needy.

**Section 13.4 Retroactive Period**

An applicant for Medicaid may receive retroactive coverage of up to three months prior to the month of application. The exception to this rule is when the individual is only eligible for the Non-Categorical coverage group or Qualified Medicare Beneficiary (QMB) Buy-In group for the retroactive period.

I. Eligibility for retroactive coverage must be determined separately from prospective coverage. It is possible for an individual to be covered as Medically Needy during the retroactive period and Categorically Needy prospectively or vice versa.

II. The individual must meet basic eligibility requirements for any month during which coverage is received. For example, a person who turned age 65 in the month of application cannot be covered retroactively unless SSI - Related disability criteria are met during the retroactive period. (For persons who are eligible for SSI payments based on a disabling condition see Part 6, Section 4.3). The individual does not have to be eligible in the month of application in order to be eligible for retroactive coverage.

The entire three months period may be covered if the individual is eligible for all three months. Medicaid will not cover the third month prior to the application month without including the first and second months unless the individual is ineligible due to basic eligibility requirements or excess assets during the intervening months.

**Examples:**

1. The individual applies in August and has medical expenses incurred in May. There are no bills for June and July. The individual has a deductible of $300 per month. In order to cover the bills incurred in May, the deductible is $900, not $300. June and July could be covered with a deductible of $600 or July only with a deductible of $300, but coverage must be continuously retroactive from the application month.

2. The individual applies in March and incurred medical expenses in December, January and February. The person had assets of $1500 in December, $2500 in January and $700 in February. Bills incurred in the month of January cannot be covered by Medicaid as the assets exceeded the asset limit that month. The person's deductible for December and February are added together. The bills incurred in January for which the individual is still responsible can be used as non-covered items toward meeting the deductible (See Part 10).

The individual who has a deductible period may withdraw from the program and reapply for retroactive coverage. If an individual voluntarily withdraws, a new prospective period begins with the month of the new application and retroactive eligibility can be determined for up to three months prior to the month of the new application.

In determining eligibility for the retroactive period, income actually received during that period is used.

Individuals who are determined to be eligible for SSI benefits and who indicate on their SSI application that they have medical expenses for the three months prior to their application for SSI do not need to make a separate application for retroactive Medicaid coverage.

If the individual meets the non-financial criteria and the Department has sufficient information in the case record about the individual's financial situation to determine eligibility for the retroactive period, the individual will be sent a notice of eligibility for Medicaid. If there is not sufficient information in the case record or no case record exists, the individual should be contacted in writing and verification of specific information requested. Due to the length of time involved in establishing SSI eligibility, especially if a disability decision is involved, requests for information should be reasonable and lenient.

Individuals who are determined to be eligible for SSI and who indicate on the application for SSI that they do not have medical expenses for the three months prior to their application for SSI will be sent a notice of denial for the three month period.

## SECTION 14 CLOSINGS AND DENIALS

Before MaineCare coverage is ended or denied, it must be determined that the individual is not eligible under any coverage group. This includes:

- doing a disability determination when there is information that the individual can potentially meet the disability criteria;
- determining medical and financial eligibility for a Wavier, Nursing Home Care, or Katie Beckett coverage groups when there is information that the individual can potentially meet these criteria;
- determining continuing coverage when SSI/State Supplement cash benefits end;
- determining eligibility under Cub Care and Maine Rx.

**Example:**
Cathi and her 17 year old daughter are eligible under Family - Related Section 1931 coverage group. Her daughter leaves the home. Cathi claims to have a significant disability and is being assessed by the Medical Review Team to determine if she meets the criteria for SSI - Related Medicaid coverage. Cathi's eligiblity under Family – Related Section 1931 continues until a decision is made by the Medical review Team (MRT).

When individuals lose eligibility for SSI/State Supplement payments and a review for continued MaineCare is needed, existing information in the case record is used to determine continuing eligibility for MaineCare. If there is insufficient information in the case record to determine eligibility or a disability determination is necessary, coverage must be continued until ineligibility is determined. If a review form is necessary, it must be sent to the individual within ten days of the date SSI/State Supplement coverage has ended.

## SECTION 15 NOTICES

Individuals will be notified in writing as soon as eligibility is determined. If some of the individuals applying for MaineCare are eligible and some are not, the notice must specify who is and who is not eligible and the reasons for each individual's ineligibility.

Individuals whose eligibility begins after the month of application must be sent a denial notice for the months of ineligibility.

All individuals who apply for Medicaid must be notified of their eligibility for retroactive coverage. Such notification must indicate the months of eligibility or ineligibility.

When an individual is determined to be ineligible, the notification will contain:

I. a statement that the application has been denied;

II. the specific reason(s) for the denial;

III. the manual citations which support the decisions; and

IV. an explanation of the individual's right to request a hearing.

In situations when the intended action is to discontinue eligibility or to reduce services, timely and adequate notice must be given to the recipient.

I. “Timely” means that the notice must be mailed twelve days before the intended change would be effective (ten days for notice plus two days for mail).

   Timely actions resulting from computer matching mass changes to Social Security and other Federal benefits require an advance notice of thirty days prior to the effective date of the action.

   The only situations in which the timely notice guarantee is not required are as follows:
   A. factual information is received confirming the death of the recipient;
   B. a written statement that assistance is no longer wanted is received by the Department. Such statement must be signed by the recipient or the recipient's representative;
   C. the recipient has been committed to a public institution (See Section 9 of this Part);
   D. the recipient's cost of care changes (See Part 12, Sections 4.3.4 and 4.4.1; Part 13, Section 6; and Part 14, Section 6.2);
   E. the recipient's whereabouts are unknown and Departmental mail directed to the recipient has been returned;
   F. an applicant for Medicaid has been covered temporarily due to the Department's failure to determine eligibility within the forty-five day time limit and is later found to be ineligible. The applicant's temporary coverage is to end three days from the date the denial notice is sent; and
   G. documentation is obtained that the individual is currently receiving Medicaid in another state.

II. “Adequate” means a written notice which includes a statement of:
   A. the action the Department intends to take;
   B. the reasons for the intended action;
   C. the regulations supporting such action;
   D. an explanation of the rights to request a hearing; and
   E. a statement explaining that if a hearing is requested within the notice period, the intended action will not become effective until after a hearing Decision is rendered.

## SECTION 16 UNFUNDED CHECKS

An unfunded or bounced check is considered non-payment of a premium.

Upon notice from State Treasury that a check has bounced, the household will be sent a notice of non-payment including the amount now due.

If no payment is received within thirty days of the 1st notice, a 2nd notice is sent.

If no payment is received, the penalty will take effect the month following the month in which the 2nd notice is sent as long as the client has received twelve days advance notice.

> **Example:**
> The family is sent a second notice of non-payment on May 10th. No payment is received within twelve days. The penalty starts in June 1st. If the notice was not sent until May 30th, the penalty would take effect in July.

The penalty is a period of time during which the client cannot get coverage under the option for which there is a non-payment. How long this lasts depends on the coverage option involved.

For **Cub Care**, there is a month of ineligibility for each month of non-payment up to a maximum of three months.

> **Note:** A family's twelve month enrollment period cannot be ended in order to impose this penalty. The penalty starts at the end of any current enrollment period.

In the example above, if the family's enrollment period was January through June, the penalty would take effect in July rather than May.

For **Transitional Medicaid** (TM), coverage under TM ends and cannot be reinstated for any remaining months in the TM period for which a bounced check is received unless overdue premiums are paid. Unpaid premiums from one period of TM do not affect eligibility for subsequent periods of TM.

For **Working Disabled**, coverage cannot continue after the end of the current or last enrollment period unless the unpaid premiums are paid.

For **Katie Beckett**, coverage cannot continue after the end of the current three month premium period unless all outstanding premiums are paid.

> **Note:** A family's three month enrollment period cannot be ended in order to impose this penalty.